

OCT 2 2 1935

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

26021

## 1. PLACE OF DEATH

County DaviessRegistration District No. 248Township LibertyPrimary Registration District No. 5344City Waverly (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Isaac Chandler Millman(a) Residence, No. 2 Albany Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-28-18597. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
75 7 298. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Wisconsin (STATE OR COUNTRY)13. NAME W H Millman14. BIRTHPLACE (CITY OR TOWN) Ind (STATE OR COUNTRY)15. MAIDEN NAME Lydice Ann Phillips16. BIRTHPLACE (CITY OR TOWN) Ohio (STATE OR COUNTRY)17. INFORMANT Son (ADDRESS)

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE Winston Mo DATE Aug 29 193519. UNDERTAKER Mrs Kate Shoup (ADDRESS) Winston Mo20. FILED 5-29 1935 J. H. McClellan Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug-29-193522. I HEREBY CERTIFY, That I attended deceased from Aug. 24 - 1935, to Aug. 26 - 1935I last saw him alive on Aug. 26 - 1935. Death is saidto have occurred on the date stated above, at 10.00 a. m.

The principal cause of death and related causes of importance were as follows:

Enlarged prostate gland  
was operated on  
transurethral following  
operation  
Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) L. R. Doolin, M. D.(Address) Gallatin, Mo.

